

In the Editor's Page ("Learning from tragedy; Tirer des leçons d'une tragédie" *Can Med Assoc J* 1996; 154: 135), Dr. Bruce P. Squires says, "Some readers may complain that only the family's side of the complex tale is revealed." He rationalizes this approach by stating that the article highlights some major problems in communication. Unfortunately, there is little evidence in either the editorial or Ms. Hunter's article that the coroner's transcript was read. Without accurate information, any lessons learned will be false.

I feel compelled to respond to the article because I worked in a cross-cultural setting with the pediatric resident involved. During this time, she provided emergency and ambulatory care to aboriginal people. Although I have worked with many residents, she was the most explicit in giving instructions. She would write things out, draw pictures and give information verbally. She brought patients back for repeated demonstrations of procedures. She was competent, compassionate and caring.

It is my understanding that, although the coroner made 46 recommendations, there were no findings of wrongdoing in the actual care that the infant received. The resident spent more than an hour with the parents and gave them written instructions.

I am a strong supporter of constructive review of medical practice. However, I was extremely disappointed to see *CMAJ* participate in an unsubstantiated attack on someone. I believe that this waters down any lessons I may have learned from this situation.

This is a personal letter and does not necessarily represent the opinion of the Sioux Lookout Program.

Claudette Chase, MD, CCFP
Sioux Lookout Zone Hospital
Sioux Lookout, Ont.

[The author responds:]

The readers' condolences are touching and cathartic. Acknowledging loss is crucial in promoting healing. Their sympathy compensates for the initial lack of understanding I received from physicians after Madeleine's death. Before having another baby, I searched for new physicians. I wrote to several stating only that I had lost a 7-week-old baby. Several refused to see or speak with me. I recounted the medical events that had led to Madeleine's death to an obstetrician who was so cold and unfeeling that I left her office feeling bruised.

Perhaps those physicians had trouble dealing with a baby's death. Dr. Goetzen notes in his article "Death of a child" that, when a baby dies, it can disturb physicians because it causes them to come to terms with their own mortality. I believe that the sweet and vulnerable nature of babies causes physicians to put aside their professional distance. When a baby dies, they seem reluctant to comment on the loss of a life. However, communicating their feelings to patients may be beneficial. Fortunately, I now have a sympathetic general practitioner, obstetrician and pediatrician.

Sixteen months later, I am still trying to come to terms with Madeleine's death. To date, all that I have described about her was her illness. It may be helpful for readers to learn about her brief life. In the sunny days of August and September, she enjoyed breast-feeding in the back yard. She adored kicking her rattles in her crib while smiling intently at her musical mobile. We hiked in the forest several times, once around a scenic lake.

A poem by William Wordsworth helps me deal with the separation from Madeleine.

*Though nothing can bring back the
hour*

*Of splendour in the grass, of glory in
the flower,
We will grieve not, rather find
Strength in what remains behind . . .
In the faith that looks through death,
In years that bring philosophic mind.*

Our new daughter, Elisha, brings us a lot of happiness. We can be reconciled to Madeleine's tragic death, knowing that she continues to touch many lives and to teach us all.

(In response to Dr. Chase's letter, the purpose of the recommendations from a coroner's inquest in Ontario is to prevent future deaths; finding fault is not part of its mandate. Since my goal in writing "Madeleine's death" was to prevent errors from being repeated, I specifically wrote without any emotion or finger-pointing. In keeping with this policy, I must reserve comment on her personal defence of the resident involved.)

Georgina Hunter, BA
Ottawa, Ont.

DOES IRON PREVENT EFFECTS OF LEAD EXPOSURE?

I would like to offer two comments concerning the thought-provoking letter "Could zinc help protect children from lead poisoning?" (*Can Med Assoc J* 1996; 154: 13-14), by Drs. Nicholas Schmitt and Paul M. Gelpke and Mr. John J. Philion, which touts the possibility of adding zinc to the diets of those at risk as a preferred strategy to cope with lead exposure.

First, not only zinc but also iron is thought to affect the consequences of lead poisoning. It is suspected that zinc limits lead absorption and that iron limits the damage to the central nervous system (and therefore intelligence) caused by lead. Strong arguments have been made that the associated iron deficiency, rather than the excess of lead, is actually respon-

sible for any diminished intelligence among toddlers with lead problems.

Second, the addition of iron to prepared infant formulas and to children's chewable vitamins has drastically curtailed clinical (and chemical) iron deficiency among both bottle-fed and breast-fed toddlers. This reduction in iron deficiency significantly predates the recent drastic reduction in lead contamination in our environment. Thus, we have seen the prevalence of high blood lead levels plummet among children less than 6 years of age, from more than 88% of those sampled two decades ago to less than 9% of those sampled in the early 1990s. A recent survey of children receiving Medicaid in California found that the lead levels in the blood of these children had plummeted even further so that less than 2% had blood lead levels higher than 0.1 µg/mL.¹ At almost the same time Kaiser Permanente in California confirmed that only 4% of 636 children tested at four different sites had lead levels in excess of 0.1 µg/mL.² In Idaho, not even one of 1500 children tested had an elevated blood lead level.

As the lead problem approaches extinction, scientists would still do well to seek further understanding of the apparent interrelations among lead, zinc and iron — and possibly other metals — and the individual and combined effect of these metals — if any — on intelligence. If we add 5 or 10 points to our collective intelligence quotient, addiction to television soap operas may follow lead poisoning to extinction.

William O. Robertson, MD
Medical director
Washington Poison Center
Professor of pediatrics
University of Washington
Seattle, Wash.

References

1. Blood lead levels among children in managed care organization — California, October 1992–March 1993. *MMWR* 1995; 44: 627–635

2. Haan MN, Gerson M, Zishka BA: Identification of children at risk for lead poisoning: an evaluation of random pediatric blood lead screenings in an HMO-insured population. *Pediatrics* 1996; 97: 79–83

NEED FOR UNIVERSITY STUDENT HEALTH SERVICES GROWING

The article "On-campus physicians witnessing changes in medical problems faced by university students" (*Can Med Assoc J* 1995; 154: 77–79), by Susan Thorne, was welcome and timely. University health services, and psychiatric services in particular, have been under siege for the past few years. As an area of medicine we suffer under the double burden of university administrations, which view us as necessary but expensive evils, and our medical colleagues, who see us as practising country-club medicine, unworthy of respect or support. Our patients suffer because of these attitudes.

From a survey we conducted at Queen's University, Kingston, Ont., we know that health plays a central role in students' decisions not to return to university. A review of first-year students who did not return after the 1988 academic year revealed that 7.6% definitely did not return because of health problems and another 20% probably or possibly did not return because of health problems. We suspect that a large number were able to stay in university because their health problems were adequately addressed at school.

As our society changes, so do universities. These changes highlight the increasing importance of our service. There were 853 visits to our psychiatric service in the 1980–81 school year. In 1990–91 there were 3279 visits, and in 1994–95 there were 5907 visits. Although we continue to serve the "classic" psychiatric needs of a

student population (i.e., students who are in a crisis or having an adjustment reaction and need help for only a few sessions), there is a second population that has formed a large portion of our practice in the 1990s. These students often require regular psychiatric care throughout their university years. The growth of this population is reflected in the growth in the proportion of patients seen by the psychiatric service who are taking medication, from 27% in 1981 to 52% in 1991. The mean number of sessions per patient doubled during the same period. This new population consists mainly of older students, who are often returning to school part-time and trying to reconstruct their lives. One particular telling statistic is that 26% of students who sought psychiatric care at the clinic in 1991 reported a history of childhood sexual abuse, whereas no students reported such a history in 1981.¹

In a small community like Kingston, can you imagine how local physicians could accommodate an additional 600 psychiatric patients and another 8000 patients seeking family medical care, for a total of 25 000 to 30 000 visits during the year, especially since most family practices are closed to new patients and the wait to see a psychiatrist is 3 to 6 months?

Can you imagine the cost in time, money and human suffering if students did not have access to timely, sensitive care? Sadly, if university health services are cut back or eliminated in the name of cost constraint, we may find out.

Stephen H. McNevin, MD, FRCPC
Associate director
Student Health Service
Queen's University
Kingston, Ont.

Reference

1. McNevin SH: The changing role of university student health service: some empirical evidence. [presentation] Canadian Psychiatric Association Meeting, Sept 22, 1995